MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, March 22, 2002
9:01 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
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FLOYD D. LOOP, M.D.
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ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Assessing the Medicare benefit package: preliminary findings
-- Julian Pettengill, Jill Bernstein

Okay, Julian, you've got the floor.

MR. PETTENGILL: Thank you. At the January meeting and yesterday, staff and a variety of visiting lecturers presented you with a variety of information that might be used to indicate directly or indirectly how well Medicare's benefit package is doing in meeting beneficiaries needs. Later this morning you will hear staff present information about options for changing the benefit package and the criteria that might be used to evaluate them.

Our goal in this session is to pin you down. You heard a lot of information and now we'd like to know what you think about it. What findings do you want to include in the June report? Does the Medicare benefit package need improvement? If so, what are the major problems? Given constrained budgets, what improvement strategies might be considered? What are the pros and cons of each strategy?

Your discussion yesterday morning was helpful in identifying some themes: your desire to identify key policy choices, and the difficulties of disentangling causes and effects because of the complex relationship between Medicare and other actors including private employers, private supplemental insurance providers, and state governments.

But we also need to know what you take away from the information you've been given, and what relative emphasis to place in the report between identifying the problem and the nature of the problem, if any, and focusing on the options and the implications of those options.

To stimulate your thinking we sent you a short list of tentative findings and little bit about ways of thinking about them. In a moment Jill will talk about the findings from the evidence, why policymakers might want to respond to the findings, and frameworks for thinking about the policy options. I want to focus briefly on the motivation for the report and the broad policy questions.

Arguably, Medicare has been a highly successful program. It has great popular support, so you might well ask, why do this report at all? Based on the evidence many might argue that for most beneficiaries the glass is something like four-fifths full. So why do anything?

One reason is that the world has changed -- and Jill will talk more about that in a minute -- and the

benefit package has not kept up. Consequently, Medicare no longer provides the needed protection for many beneficiaries. Many beneficiaries appear to be able to manage on their own resources but quite a few have difficulty obtaining a reasonable level of protection.

To give us guidance for writing the report you could answer questions such as those on the overhead: does the benefit design limit beneficiaries' access to appropriate care? The second question really relates to the idea that we're probably spending enough money overall to furnish beneficiaries with the care they need if you consider both Medicare and all the various private sources. Is it possible to recast the way the money is managed to better ensure beneficiaries' access to care and improve their financial protection?

Alternatively, you could take Bob's questions from yesterday morning. He identified three separable questions. First, how comprehensive does the benefit package need to be? Second, how do we deliver that benefit package to beneficiaries? I take that to mean, does Medicare do it all or do we split the responsibilities somehow between Medicare and private entities as we do now? And third, how long should the public subsidy be? You can get various estimates of what the current public subsidy is depending on how you count it, to what extent you take into account beneficiaries' past contributions during their working lives and that sort of thing.

Now I'll turn it over to Jill to talk about the evidence.

DR. BERNSTEIN: I want to go through the evidence fairly quickly. You heard a review yesterday morning and then you heard evidence all morning and I'm pretty sure you don't need me to tell you what you heard. But what I do want to do is talk to you a little bit about how we want to characterize the evidence and how we want to make a case for whatever it is we decide we're going to make a case for.

This first slide refers to three different kinds of evidence. One having to do with the fact that people supplement Medicare as an indicators. Secondly, we talked about a lot of problems with access to specific kinds of care yesterday, and also about financial barriers. And thirdly, about the financial burden for some beneficiaries and for their families. I'm going to go through these in three separate slides, not in the order that are on this slide. It's not because I don't think you're paying attention but because I want to deal with the supplemental

issue third.

The next slide has to do with access. Although most beneficiaries have access to care that they need, there is evidence that some people can't get the sorts of care they should have in the most appropriate setting.

It's really hard to separate access from the ability to pay, but as we already just talked about the basic design of Medicare, which is a fee-for-service program and the acute care model it was designed to accommodate, present barriers to the coordination and management of care, particularly for people with complex care needs. That's not a problem created by Medicare's benefits package but rather a reflection of how fee-for-service health care works.

But we also heard evidence yesterday that some beneficiaries don't get care they need or that they experience avoidable problems such as decline in functional status related to problems with mobility or vision or hearing because of gaps in the Medicare benefit package. The most obvious problem is access to prescription drugs, but we also heard about problems associated with coverage of some preventive services, some medical therapies, devices, et cetera, which would include things like glasses and hearing aids which are expensive and are not covered by Medicare and not by some forms of supplemental insurance.

There are also areas where specific or peculiar details of Medicare's coverage appear to create some difficulties. Some of these are closely related to payment policy. We heard yesterday about the problem with mental health benefits. There's also an issue that the Commission has dealt with before about the coinsurance rate for outpatient services; 50 percent copay could be perceived as an access barrier for some people.

But it's also clear that access problems are more prevalent among the most vulnerable populations, including those with low incomes, people in poor health, and the oldest-old beneficiaries. The factors that contribute to access problems are also related to the ability to obtain supplemental coverage.

The next slide deals with financial liability. I think some of what we heard yesterday was very helpful in sorting some of these issues out. Beneficiaries use more health care and spend more on health care and have lower incomes than non-Medicare adults in their fifties and mid-sixties. Beneficiaries' cost for Medicare cost sharing, non-covered services, and premiums for supplemental coverage are all increasing.

For people with relatively low incomes, the cost of health care can create financial hardship. The data presented yesterday showed that about one in 10 beneficiaries' income minus their out-of-pocket spending for health care equals poverty.

Dan's analysis also showed that beneficiaries' out-of-pocket health care costs rose at about the same rate as their incomes for much of the 1990s, leaving out-of-pocket spending for health care costs at about 18 percent, which is about what it was right at the time that Medicare was passed, on average. Beneficiaries' incomes are now much higher than they were then and they're better protected for other reasons, but health care costs are now taking up a larger part of their household budgets than they have in a long time because throughout the '70s and '80s the number was more like 11 or 12 percent of income compared to the 18 percent that it crept back up to in the 1990s.

For about half of all beneficiaries the budgets that they're working with are very low. That is, within 125 percent of poverty.

Now let's turn to the issue of Medicare supplementation which was a little trickier and we're still trying to get this right. This slide reflects that we were thinking a couple days ago, but let's work with it here. Pretty much everybody who can supplement Medicare does, with the important exception of people who are eligible for assistance through the QMB, SLIMB Medicaid provisions where we discovered that there are a lot of people who might be able to get some help who aren't.

There is evidence that not having supplemental insurance or coverage of any kind is associated with underuse of some services, including prescription drugs, but possibly some other services as well. We're looking at some additional data that we'll bring back to you in April that will look at that even more closely. There are some studies that we've heard about that we need to track down that looked at differences in surgical access for people without supplemental care as well.

We also heard that the evidence shows that there are higher rates of use for some health services by people who have different kinds of supplemental coverage. It may be that first-dollar coverage creates incentive to use some services when it's not clear whether the services are actually necessary or valuable.

More important probably is a finding that we don't have, that Jeanne Lambrew couldn't give us and no one else

can either. That is we can't say with any certainty what's going to happen to the different forms of supplemental insurance over time. The evidence suggests, however, that the availability and affordability of coverage may become more problematic.

Now let's turn to the even harder part. I'd like to move from how we characterize the evidence to what we do with it. What we need from you is a discussion that will let us know whether you're comfortable with the characterization of the issues, and whether this or some other way of presenting these issues defines a reasonable or workable basis for the further discussion of policy options.

The evidence that we've reviewed suggests that some of the gaps in Medicare's benefits may in fact directly or indirectly divert beneficiaries and/or practitioners from choosing the most effective or cost effective treatment options. This could be related to cost-sharing requirements, or failing to pay for preventive services, or some of the other things we heard about.

The basic goal of Medicare as we understand it was to ensure that retired older Americans who couldn't work or weren't working any more had access to mainstream medical care, and that they didn't have to impoverish themselves or their families when they became ill. The evidence indicates some beneficiaries have to spend a lot of money out-of-pocket for uncovered services and for premiums for insurance that they feel is necessary just because they have to fill in gaps in Medicare.

We also found that the way that many beneficiaries deal with the perceived problems of Medicare benefits, which is having multiple forms of insurance, leads to high administrative costs. To the extent that supplementation contributes to the use of services that are of little or no value, this additional insurance may also increase the cost for Medicare and ultimately to beneficiaries through higher premiums.

The bottom line is that our current solutions to the perceived problems with Medicare benefits do not appear to be very efficient. We might prefer them for a lot of other reasons, but there are problems with the way we're currently spending money.

Now moving to the next slide. Why are we doing this now? Even if we agreed that there are problems and we need to talk about them, does it make sense to do this in the current policy environment? The basic reason that we can offer for doing this now is that a huge public program

should not preserve structures, in this case Medicare's benefit design, that undermines its ability to meet its own goals effectively. The benefit structure is and should be an issue whether or not there's any major reform legislation passed now or in the next couple years.

Most of the major reform proposals under discussion involves the addition of benefits, mostly drugs, or rationalization of cost sharing, or both. Some reform options would employ market forces; that is, competition based on cost and quality, as a means of increasing efficiency in Medicare.

Based on the experiences of large systems like FEHBP, many analysts believe that competition can work only if the core benefits package is comprehensive. Otherwise, people with greater care needs would select the plans with richer benefits leading to spiraling premiums in some plans and favorable selection for others with healthier enrollees. That would leave lower income beneficiaries with greater health care needs at risk of being unable to afford a plan that meets their needs.

In short, the benefits design is crucial to any restructuring options.

But our review also suggests, at least to us, that focusing on benefits is worthwhile even if reforms are designed to be incremental and essentially budget neutral. If there are ways to improve the efficiency and effectiveness of the health care Medicare pace it would seem reasonable to implement reforms sooner rather than later.

Now I want to talk briefly about how we can -- one way that we might want to frame some of these options that we're going to talk about later this morning. I'll just divide them into two piles for the time being. One is improvements that we can make without increasing any Medicare program spending. The other are improvements that would probably increase Medicare spending but not might spend total spending for beneficiaries' health care.

There are actually two kinds of changes there. One is expanding Medicare benefits directly. The other is dealing with the structure and relationships between Medicare and other payers.

What we need is your input on how we should frame this discussion of policy options, and on the emphasis you want to attach to this part of the report.

The first category of options includes changes that would be designed to be budget neutral; would not increase Medicare spending relative to what we expect it to

be under current law, at least now. For the most part, this would be reworking deductibles and cost sharing. There are also some possibilities for introducing some supplementals or special programs within Medicare that deal with patients with heavy care needs or whatever, under the condition that those programs are expected to be, or are more or less demonstrated to be cost efficient.

The second broad category reflects discussions we heard yesterday about total spending for health care for Medicare beneficiaries. What we heard basically was that there's a lot of money out there. Ideally, it would be possible to design a way to provide more comprehensive coverage for beneficiaries without increasing total spending, just moving the money around. This category could include two sorts of options. We could add benefits to Medicare's package or change the roles and responsibilities of Medicare and other payers, including supplemental payers, or Medicaid, or VA or whatever.

In the presentations you'll hear later these options are sorted a little bit differently into cost-sharing changes, specifically changes that would add benefits to Medicare, and reallocating resources among payers. But the cost implications, that is whether they're budget neutral with respect to Medicare or to the system as a whole will also be discussed. Most of the options that we're going to present involve very difficult decisions based on a variety of considerations and assorted tradeoffs, and sometimes conflicting goals and values.

In the next session staff are going to present specific criteria for describing and comparing policy options that we think capture the major dimensions of the values and goals that need to be considered and traded off when considering these options. Before we get there, however, we need your input on how to frame this discussion on policy options for the June report.

MR. HACKBARTH: Before we proceed with the discussion, it would be helpful to me if we could just try to envision what the report looks like, not in detail but more broadly. At the beginning yesterday we talked a little bit about it being a report without specific boldface recommendations such as the ones we usually have in our March report. We talked about it being more educational in nature in helping people structure choices, and a look at different possible policy directions.

Here you've laid out one of the big policy crossroads, if you will, that we alluded to yesterday. Are

we trying to resolve that and say, on balance the commissioners think that this path is better than that path? Or are we simply trying to say, as you work through these issues you come to this crossroad and the arguments on this path are these, and the arguments on that path are those?

I'd welcome your thoughts about that, Murray, but I think all of the commissioners ought to weigh in on that. It's a critical issue.

DR. REISCHAUER: I guess I would at this stage be in favor of us taking the broader approach and saying, if you want incremental reform or rationalizing the existing system here's a set of actions that one can take, if one wants to try and strengthen the system in a more fundamental way, this is the way to go. Because I don't think the debate in Congress has reached an overwhelming consensus that one is preferable to the other.

DR. ROWE: Just on this issue before we get to some of the others. What horizon were you thinking of, Glenn, for this? Is this the recommendations that we think should be put in place now to prepare the system more effectively to deal with the beneficiaries' needs over the next decade, or is this the beginning of a discussion of more fundamental changes to deal with the dramatic increase in numbers of beneficiaries that might occur at such and such a time or whatever?

Whenever you're doing a strategic planning exercise you're trying to think, is this a three-year or a five-year or --

MR. HACKBARTH: Good question.

DR. ROWE: I think that would be helpful to me in terms of responding to your question.

MR. HACKBARTH: Because we haven't focused on the really fundamental imbalances due to demographic changes and all of the financing issues and the like, I think implicitly we are talking about a shorter time horizon. Whether it's the next decade or next five years or something, I'm not sure. But I don't think we're talking about the next 20 or 30 years based on the discussion we've had thus far.

MS. ROSENBLATT: I don't think we can do that. I think we have to look at the long term. I served on a technical advisory panel, looked at the trustee's report. Ariel was involved in that. There's as huge baby boom bulge coming up. I think we have to look at -- they usually run 75 years, and I consider anything in health care projections over three years to be way out there. But I think we've got to think in terms of maybe 25 years or we're not really

facing reality.

DR. NEWHOUSE: My question is whether the Congress really is expecting to hear about the 2020, 2030 issues from us or not. There's no question that they're there. My personal view is actually the trustees are too optimistic. But again, the Congress may not be looking to us for advice on this set of issues. There was the bipartisan commission, there is the trustees' annual report to them.

MS. ROSENBLATT: Can I just respond to that? There's us as a commission and then us as individuals. As the actuary on the panel there's no way I could say, don't look at the 25-year picture. My profession would force me to go in that direction.

DR. REISCHAUER: I'm having a hard time following this conversation. We're talking about adequate benefit packages, not necessarily the financing. The financing is a totally different issue, which gets to my third question which is, how deep should the public subsidy be? You can have a narrow benefit package or big benefit package, subsidize either a small or a large portion of either of them. I think we're focusing on benefits that are cost effective in some sense, so we're being responsible in that way. But I'm not sure what the 2025 problem is in this context as opposed to current policy.

MS. ROSENBLATT: The minute you touch the benefits that are publicly funded you impact the balance of the trust funds.

DR. REISCHAUER: If we say how we touch them is going to be paid for publicly as opposed to through high cost-sharing and higher premiums. But we haven't said anything about that at this point.

MS. ROSENBLATT: That's true.

DR. REISCHAUER: As I said, these things are being paid for now somehow, by employers, by individuals, whatever. If you could capture all that money somehow, which I know is politically infeasible and technically difficult to do, but step back and imagine you could, you could have a much-expanded benefit package without putting any more burden on the government than now exists.

MR. FEEZOR: Just a little bit of departure from the preceding comments. I would hope that the report early on would send the signal to Congress that Medicare as probably the single largest payment in the health care industry forms a foundation by which health care is paid or the incentives in which the operates, so at least frame it in that regard so that maybe it does provide Congress an

opportunity to think a little more broadly then just tailoring some benefits, whatever the horizon we decide to pick on.

MR. SMITH: I think Allen is right, but let me try to pick up on Bob's point. Julian, actually it's a question for you. We've said several times this morning and we said several times yesterday that we think there's enough money in the game. I think that's right, but I think we ought to have a little bit of skepticism about that. If everybody got all of the drugs that are necessary, if drug costs keep expanding, if everybody who needs an extra pair of glasses had them; I just think we ought to be a little cautious about whether or not there's enough money in the game.

We know and it's implicit in Alice's comment that even if there's enough money per capita, the share of GDP that's going to be devoted to health care and the subset of that that's going to be devoted to Medicare is going to grow. That is going to raise questions of where does it come from, how do we subsidize it, what's the appropriate level of subsidy?

I think we can't avoid thinking about those questions, at least in the medium term, Bob. I don't know if we have to go out -- we certainly don't have to go out the trustees 75 years. They don't do it very well and we are unlikely to do it any better.

But it would be crazy to think about a benefit package as disconnected from beneficiaries and the growing population of beneficiaries, which are also going to place a new set of burdens on the delivery systems, and the appropriateness and the adequacy of the delivery structures both in geographic and simple size terms. So it seems to me we need to think about that, and that raises another set of financial questions that are appropriate.

But my guess is that the best thing that the June report can do is be a conversation guide for a conversation that's going to go on over the next four or five years. Congress isn't going to do anything decisive between now and the presidential election, but the conversation is going to continue, and it will happen episodically and in fits and starts.

It seems to me what we ought to be trying to do here is to provide two lists that help shape that conversation. One is a list of what's an appropriate benefit package, and what have changes in technology and treatment modality, what have they meant and what do they require in terms of a simple update?

But the second is, what have we learned about the health care system that ought to affect system design? What are we trying to get out of this? We heard yesterday, and we all know that issues of coordination of care, and issues of the odd intersections between payment systems and delivery systems create both inefficiency and inadequacy. We ought to speak to that, because part of a good benefit package is ensuring that appropriate coordination happens and that both the frictional losses and the gaps are filled in as much as possible.

What we ought to be trying to say in this report, here's an adequate benefit package, or an appropriate benefit package, and here are the systemic issues that occur when you try to deliver that package. And here's how Medicare, both on its own but its role as bellwether for the health care system, here's how Medicare can structure itself to deliver that package most efficiently.

It seems to me we want to try to do both. Maybe it's A and B, but I would hope that the report informed the country's conversation, which will happen whether or not we do anything, and it will happen better if the June report provides that kind of guide.

DR. NELSON: I'm coming down the same place that Dave does but I articulate it a little bit differently. The most valuable thing that I heard Jill say to me was that the program is not structured and operating now to meet the program goals and fulfill the statutory promise. I think our report, that ought to be the basic message; say it's not meeting program goals, operating to meet program goals in the following ways, and identify possible solutions.

I think we have to ask ourselves whether our report can contribute something different from the steady stream of broad policy analysis that's going on with respect to the Medicare program and the benefit package in particular. We ought to try and identify a way that we can make a contribution that's different from all of the rest of this work that's going on.

MR. HACKBARTH: Alan, do you have any thoughts on what our distinctive contribution might be?

DR. NELSON: Yes, the third point that I'll make. I think that if we are to -- it's hard for me to see how we can make a contribution if we just lay out all the options. I think that there's some risk in it, but I think that we ought to identify what the best benefit package would be to meet program goals in the statutory promise, and identify ways to get there. I think just saying, here are all the

options, that's being done by everybody.

Now whether we have credibility to identify the best way to go about it is another issue I guess we could discuss. But I think we ought to at least try.

DR. ROSS: A couple thoughts. One, to pick up on Alan's, that is the issue here, is what's the comparative advantage of MedPAC as a commission versus many of these other reports that are out there? I guess my read of it is, so many of them have focused purely on the financing side of things, and I've read 1001 discussions of the baby boomers are coming and I think that's now an established fact.

You can't fully separate benefits, payments, and financing. We keep trying to. We do payments in March, and now we're trying to do benefits in June. But I also think you can say enough about them as somewhat stand-alone items. Under any reform proposal I've read about recently, traditional Medicare is going to be around for a long time, however it's financed, with some combination of Part B premiums or additional premiums or anything else. That program will exist. It has to have some specified benefit package in it. That's something to think about.

Where should the Commission go on recommendations? I think there's value added if you do lay out options that have not been discussed fully and thought through, and the tradeoffs you make in going one direction or another. This is the Commission's first crack at this. I think there's ample room for further discussions as you go down the road, but I think there's a value added just in the discussion.

Of course, if you're comfortable going beyond that, that's your decision to make. But I think even getting the different forks in the road laid out on one table by an organization that doesn't have an ax to grind is a useful contribution.

MR. HACKBARTH: Before I go through the list can I just pick up on that list point? The amount of time that we have spent on this, the amount of time that we have to spend on it before the June report is really quite limited in comparison to the scale and complexity of the issues. So I like the way Murray thinks about it. I don't think this is necessarily our last crack at these issues, and I do think we would be making a contribution to simply frame choices and some of their risks and benefits at this step, allowing us to come back at a subsequent point and delve further and make more specific recommendations. The time constraint is very real.

MR. DeBUSK: Some of the things that Murray said

there encompassed some of the feelings I have in relation to this. Of course, the financing piece is a major, major piece of it. I understand about the statutory promise -- I don't know as I totally understand; I'm aware of it and the program goals. But we're in a situation where there's no end to the utilization of services. There's got to be some deterrent, some kind of cost-sharing program. The many forms that it's taken in the present system, although not perfect, seems to be a partial answer or addressing the problem.

But going back to the utilization of services and there's no end to it. Ralph, I think there was a model in Great Britain a few years ago for some of the fund-holding entities over there where they opened one region up and said, okay, we're just going to treat everybody open. And of course, it's totally paid for, totally socialized. It was unbelievable the utilization within that region.

So it's no different here. We can never get the perfect system. There's going to have to be some kind of deterrent in whatever we put together or whatever we recommend because there's no way we can ever afford it all and address it. Well, you all are aware of all this, but I think behind all this you've got to keep that in mind in trying to model something going forward. But all the entities that are in it now, looks to me will have to continue to be players, where the employer is involved, where the family is involved in coming up with copays and what have you.

MR. HACKBARTH: Let me just think aloud here about how we manage our time. We do have seven or eight people that want to comment. What we started to do when we opened up this dialogue was try to -- the question I asked was, what exactly are we trying to produce in our June report? Is it a map with options as opposed to distinct recommendations on which path to choose? I think that's the threshold issue that we need to get across and then turn to some of the more substantive issues that Jill and Julian have tried to frame for us.

So I don't want the conversation just to wander off and us to use all of our time making general statements. So could I ask people in the queue here, do you have a comment on the specific question of what we're trying to accomplish with the report? Let's keep our comments focused there.

MS. NEWPORT: I guess the fundamental question is, how do we best serve what constituency? Is it to provide a

nexus of data that is useful and that will inform that political debate with our expertise in terms of all the complexity that comes together with moving the boxes around or creating opportunities to seek efficiencies, if there is truly enough money in the system that could fulfill the promise? I liked very much the way David put it, but I think we do need to get to what is the most useful product that we can come out with that may be just the first chapter of a much longer exposition on this.

But I think that what I found very useful yesterday and today is the melding together or amalgamation of a lot of information and then being able to start, at least in a formative state, explain what we've learned in the past in terms of the interactions of these things, the challenges that we might have in terms of access.

But I do think that the question I would like answered at this point is, is the constituency the House and the Senate, and what would they need? If that's a longer term, 20-year piece, that's fine. But right now what we have, and given the time constraints, is that we can probably take hopefully a balanced view in pulling together some information and identifying some further work or some further focus. So I have a question that's buried in there, but I have to say I felt very comfortable with what David was saying as well.

MR. HACKBARTH: As always, our principal audience is the Congress, but it's not our only audience, would be my initial response. Here we are answering a question that was no specifically asked, unlike our March report or the various mandated studies. So I don't think we can crystallize with precision what our customer is looking for or providing something that they didn't ask for. So I think it's not productive to try to answer that question in great detail.

MS. NEWPORT: I know and I wasn't trying to be more disingenuous than I normally am. I really do think that every once in a while let's focus on what we're trying to do and what we can accomplish in the reasonable term. So I think that it is important for us, maybe every once in a while to remind ourselves that there's a limited amount that we can accomplish, what would be of quick utility, short term utility. But also take the opportunity to maybe lay some groundwork for future work on this.

DR. ROSS: Just a quick reply to Janet. I think given the diversity of approaches that you see coming out of the House and the Senate and the two parties, you can't

address every one of them. But that does suggest what there is need for is, again, some reasonably objective and analytic thinking of laying out the groundwork. Here are the issues, here are the resources available, here are the constraints you face. Because no matter what approach they take they'll have to confront the same reality, and trying to give them a reasoned description of that reality and the tradeoffs they're facing, I think that helps all of the parties involved.

DR. NEWHOUSE: I'm a little unclear about where we are in this discussion. That is, are we still talking about the macro level issues of the June report or are we trying to get down to the material that Julian and Jill presented?

MR. HACKBARTH: The macro issue. Again, I'd ask all the people in the queue to try to focus on that. I think we're using up a lot of time here.

DR. NEWHOUSE: I had a specific comment on the material presented.

MR. HACKBARTH: Hold it then for just a minute and I'll get back to you.

DR. NEWHOUSE: I should say, the macro points I agreed with Bob Reischauer and Murray on how to structure the general report in light of the time we have.

DR. LOOP: I think it's important that we try to force Congress to think long term, at least up to 2030. I think it's impractical to think about increasing spending within the current program because the demographics are such that the spending will increase anyway as the baby boomers start in 2010.

Another variable in this that we have to consider is that employer funding of the retirees is probably going to disappear over time.

The third point I want to make is that the young-old are a lot healthier today than their counterparts. I think if you reach 65 you have a 70 percent chance of living another 20 years, and that's probably going to stretch out further. So there's going to be a lot of diagnosis and a lot of treatment, and as we already know from yesterday, a lot of chronic disease that needs attending. So I like the idea of staged benefits, the younger people have more deductibles and more copayment, and then the older-old start getting cared for with a full subsidy.

But one thing that I would really like to have us address in this report is protection against catastrophic illness for all seniors.

DR. BRAUN: Actually I agree with a lot of what

has been said. I do think though that it's important for us to consider a comprehensive benefit package and then consider the ways of financing it. I think what we're saying is that there is money in the system and the question is just how to move it around in order to finance it. But I think the basic thing is to try to see what is a comprehensive benefit package.

The other thing I wanted to ask also was access. When we're talking about access in the present time, are we talking about access to presently covered services, or are we talking about access to clinically appropriate care? I think it's very important for us to define what we're talking about because we frequently say access is okay. Access is really not okay to a lot of things. A lot of people are not getting medication because they can't afford it. So I think we need to make that definition when we talk about the present situation, what are we talking about when we talk about access.

MR. MULLER: I find the framework that was posed helpful. I wouldn't see this an either/or framework but together, because I think a lot of what was discussed yesterday showed that interrelationship between the various supplementary packages and basic Medicare. For example, even the conversation that has been going forth and will go forth on prescription drugs could be informed by pointing out that a lot of these drugs are being paid for right now out-of-pocket. We may consider that portion of out-of-pocket to be unfair by some policy standards, but between the retirees and Medigap and Medicaid this is being paid for. There's a lot of unevenness in it.

So from my point of view, looking at this framework of what perhaps -- from a point of view of system effectiveness and efficacy, might be better made in a more coordinated way, if perhaps it were done inside Medicare. Obviously that has consequences in terms of what one puts into the federal government versus in private and other kinds of budgets.

But this kind of framework that points out where Medicare benefits fit in with other sources of health benefits and allows for the understanding to go forth as to how choices that are made are not necessarily just choices of putting more things into the Medicare package at taxpayer cost at a time that everybody is worried about that, but also if that choice is made there may be some ways of relieving other budgets and even thinking of ways of -- I don't quite know how to bring that money back into Medicare

if one relieves the Medicaid budget and so forth.

So I would vote for staying with -- this framework I think is helpful. I would make it not an either/or but these two frameworks in some kind of continuum. Then I would use it -- I would take some illustrations. Obviously the drug one is the important one, but perhaps also the issue of the comprehensiveness of care. That's an issue that I think most people are very much concerned about around this table and elsewhere -- and point out how comprehensiveness or lack of comprehensiveness there is inside the system right now.

I think we got a very good start on that yesterday. So that would help us to point out where there's some gaps in the comprehensiveness, if that's a word, of the care package inside this framework. That then ties benefits and financing together. Because I see the way this framework is posed as having a very central financial framework.

DR. LOOP: I wanted to react to what Bea and Ralph both said about a comprehensive benefit package. In theory, I agree with you, but I think that it's like the definition of the efficient provider, whatever that is. The comprehensive benefit package is a floating concept. It's driven by all these changes in science and technology that will occur and never end. Once you give somebody a so-called comprehensive benefit package and define it, you can never take it away. So I think that's the problem with defining a strict comprehensive benefit package because it can only enlarge.

I like your idea but I don't know how to do it is what I'm trying to say.

MS. ROSENBLATT: I think MedPAC has a lot of credibility and I don't want us to lose that credibility. I like the idea of putting out choices, but I think it would be irresponsible of putting out choices on benefits without considering all the different funding issues connected with that. One thing that I didn't see in our background information is the difference in funding between Part A and Part B. I don't think we can ignore that as we talk about how to redesign the benefit. Because moving benefits from Part A to Part B changes things from general revenue versus payroll tax.

So I think our contribution could be, if we do it right, how do we lay out an analytic framework for policymakers to use in considering the choices? I would say the concept of budget neutrality for one year is absolutely

not enough. The trend rates of these different benefits -- prescription drugs have a very different trend rate, given the way the science base is changing, than the trend rates for hospital, the trend rates for outpatient care.

So you've got to look at -- if you want to consider budget neutrality, you have to consider budget neutrality over some suitable length of time. If we could lay out somehow what are the costs of doing that, what's the impact on payroll tax, what's the impact on cost sharing? How do all the pieces fit together? How do we lay out an analytic framework for doing that?

That is not a simple task. I'm not sure we've got enough time to do it. But if we could even make a start in doing that, that's where I think we could add value.

Now yesterday or this morning somebody mentioned actuarial studies. I would certainly hope that those actuarial studies that we're going to start on in terms of laying it out are not looking at budget neutrality for one year. I think that would be totally inappropriate.

DR. ROWE: I think the report should have four parts and I would propose that this work that is being done now handle the first three, and that the fourth perhaps be discussed at the retreat. I think the first part should be an explication of what is referred to in one of the early slides as aging of the population. It's not just simply more old people.

There is the myth of the elderly. When Medicare started there was an elderly. That doesn't exist any more. We have at least two major elderly populations: a rapidly growing old-old, increasingly frail, multiply impaired, often irreversibly ill population with a 40 percent demential rate. And we have a young-old population with rapidly decreasing disability rates, increasing activity, functional capacity, and different needs. In addition, we have subsets of the elderly population that we've increasingly spoken of in the last year or two here and that deserve attention.

So I think that there is the myth of the elderly, of the beneficiary population. It's not just the aging of America. That would be one section. There's a lot of interesting material that we can put in that.

The second set I would say has to do not with just changes in technology, which is on one of the slides. I would say the second set are the changes in production, distribution, and financing of health care services for these elderly populations. The changes that have occurred

and what their implications are.

Production: we have different providers. We talked about that yesterday, different kinds of providers. We have different sites of care: ambulatory surgery centers, more home care, rehab hospitals, more outpatient, less inpatient, et cetera. And financing: less employer-based benefits for retirees, the Medicare+Choice program, all kind of different financing things. So we have changes in the production, distribution, and financing in addition to technology in production of the services for these elderly populations.

The third section might be the implications of the intersection of these two sets of changes for the Medicare program. Do we have two different programs like Floyd suggested? Maybe not everybody should be dealt with equally financially because there are two different populations, et cetera. Try to lay out some of the questions and the framework. If we do a good job in that, that will be a contribution I think.

I don't think we can go further than that at this point without much more discussion and analysis, and I can't imagine us as a group getting it done by June, even though I can imagine Julian and Jill getting it done by June maybe. Maybe the retreat would be a great place if we could get those three pieces written and everybody read them and understood them, we could have a robust discussion about whether we want to make some proposals going forward. That's how I see it.

MR. HACKBARTH: Jack, in that framework where does the discussion of supplemental insurance and the issues that Alice and Bob helped framed yesterday fall? Is that future --

DR. ROWE: I would include that in changes in the financing. That the employer benefits are going down, Medigap may increase as M+C decreases, et cetera, the pharmacy benefit if it's not handled, there might need to be two new Medigaps proposed. I would include that in that last part.

DR. REISCHAUER: But you aren't really suggesting that we talk at all about revisions to the benefit package then. This is all the build-up to that.

DR. ROWE: I was going to say that we would talk about them but we would not make specific proposals. We would say that a recognition of these kinds of changes in the population and their needs urges the availability of certain kinds of benefits that may not currently be

available. I don't know what those would be. I would have no hesitation to do that; not at all.

The hospice benefit is an obvious benefit that if we had looked back 20 years ago somebody would have said, look, there needs to be a hospice benefit for this population. There isn't one; let's invent one. If there are other things like that, I would embrace that. I'm just trying to take what I'm hearing here and organize it in a way that's iterative.

MR. HACKBARTH: I welcome your comment, Jack, because we do need to get down to the concrete and try to frame this report. What I hear you describe overlaps substantially with the framework that I think the staff has been presenting.

DR. NEWHOUSE: I like this, I think, on first hearing it. But in any framework we're going to have some discussion about financial liability. Indeed, that surfaced here. So I wanted to talk about how to frame that. I would have started with the notion that the issues are really protecting against large losses and paying for low income or poor populations or what special protections there are for them.

Then I think I would go to our data, which to me show that the major issues creating financial risk are the omission of drug benefits and the omission of long term care. I would include the portion of the Med supp premiums that go to cover drugs, insofar as we could estimate that. I think long term care is somewhat a little different footing because the risk is more to the estate typically than to current standard of living, but it overlaps.

Then secondarily, there's an issue about the lack of stop-loss provisions in Medicare A and B that's mostly handled by supplementary insurance. We have that now, but not fully so because everybody doesn't have it and that leads us on to the point, this is a very expensive way to provide catastrophic coverage.

What I would not do in terms of narrower points, I would not talk about the incomes of the elderly being a third lower because it's not clear that consumption needs of the elderly are similar. All the retirement advice columns say you need 80 percent of your income or some such and so far. I would not talk about the out-of-pocket share on medical care of income being doubled because it all has to add up to 100 percent and as Bob said a time or two ago, what do we want them to spend it on.

I think I would not, if we talk about -- I would

not talk about adequate supplementary insurance unless we're -- in the context of what we really want the supplementary insurance to do is protect, if there is supplementary insurance is to protect against financial risk. And if there were a stop-loss provision and a comprehensive benefit package or a coverage of drugs, as Bea said, we wouldn't necessarily need this extra administrative expense; the points that are here now.

DR. REISCHAUER: I like Jack's approach but it strikes me it got us up to the bar but we didn't order the drink. Building on something Alice said, I think there's a very simple exercise that all of could go through without worrying about 2025 or financial burdens or anything like that. That is, if we had no Medicare system at this point and were given a budget equal to $248 billion, how would we design a benefit package. We certainly wouldn't have a one-day hospital deduction of $812. We wouldn't have no prescription drug coverage. We wouldn't have lots of things that are in there, and we would shift things around.

That, it strikes me, is a contribution that we can make without getting nervous about the future. We'd probably have much higher premiums, because we know people are paying premiums outside for these things. We'd probably have copays in laboratory and home health and smaller copays elsewhere. I think saying something about what an appropriate benefit package, given the technology, the population, the delivery system that we have now would be an appropriate last chapter to Jack's report.

MR. HACKBARTH: So here's what I hear as the framework of the report and what we're trying to accomplish. Again I'd emphasize that I think it really does overlap very substantially with what the staff initially brought us. We need to lead with this explanation of the context, the discussion that Jack referred to of the population being served and how it may be different and more diverse than some people think, and the corresponding changes in the care delivery system that have been occurring. So that's the contextual foundation for what we're doing.

Second, this is a report about benefits, as we initially stated, but an important theme throughout needs to be that benefits cannot be totally disconnected from changes in the care delivery system that have happened and may be needed in the future, as David was saying, or for that matter with payment and other issues. This is not easily abstracted from all of those other points.

Third, we can clearly, I think, structure some

choices, some alternative paths that we might take. Bob has presented one way to think about how you might frame one of those paths. I'm not sure we're ready to say that that is the one necessarily to take, but I think we can provide a lot of structure for future thinking by this Commission and others.

Fourth point is that as we look at those alternative paths we would be remiss if we didn't make early and frequent reference to the long term fiscal challenges facing the program, and the country for that matter. It is an important consideration in ultimately choosing among the alternative paths we may lay out. So those are four pieces of common ground that I heard in the comments.

I think we would really now need to move forward with what would be item three on my list. Yesterday we spent a lot of time talking about the context, the population, the delivery system, changes and what may need to change in the future. I don't think we need to go back there. We also talked a bit about the interconnection, and that will be an ongoing theme.

What we really haven't done is say, concretely here are the paths that we want to present, here are the crossroads that we want to really focus on in the June report, and here's what we want to begin to say about the merits and demerits of different alternatives. So I think that's where we are in the conversation. I'll put a question mark at the end of that. That's the critical issue for me, leading us to a point where it fits with what we have prepared for the rest of the day.

DR. NELSON: I agree with that. I would like to see explicitly someplace in the report the fact that when Medicare was passed it promised to Social Security beneficiaries health insurance coverage with benefits that were comparable to those that workers and other Americans received.

Over the course of the last 40 years insurance coverage under Medicare has not kept pace with the changes that have occurred among other insured Americans; the most visible example being drug coverage. That's what I meant about not meeting the promise, because it hasn't evolved as the private marketplace has. And I don't think you can say its inertia has resulted in a superior product.

MR. HACKBARTH: Looking at our planned agenda here we are -- I'd welcome, Murray, your guidance on this. The next item that we had scheduled on the agenda was the criteria for evaluating the potential directions we might

take, which seems to fit well for me. I'd suggest that we move to that. We're running a little bit behind schedule here.

Before Julian and Jill depart, any thoughts, guidance in particular that you need before you lose us, other than the right answers?

MR. PETTENGILL: That's just what I was going to ask for. We sent you a short list of findings, and we put those together fairly cautiously. We were not being aggressive in the way we stated the findings. Since no one has, I don't think mentioned any of them --

MR. HACKBARTH: Could I ask that rather using the time right now that we send those or phone Julian and Jill with them?

Thank you.